September 25, 2019

Commissioner John F. King
Two Martin Luther King, Jr. Drive
West Tower, Suite 704
Atlanta, Georgia 30334

Dear Commissioner King:

The Medical Association of Georgia (MAG) has over 8,000 physician members across all specialties and practice settings. One of MAG’s programs is third party payer advocacy where our physician members bring insurance issues to the organization to obtain help with negotiations or communication with the insurance company or for MAG to advocate for legislative or regulatory changes to address the issues. Four of the most common issues are prior authorization, assignment of benefits, network adequacy, and deselection/take-it-or-leave-it contracts.

1. Prior Authorization
Prior Authorization is the process where insurance companies and pharmacy benefit managers require physicians to qualify for payment for pharmaceuticals, procedures, and other treatments for their patients. This process is implemented as a means of controlling costs; however, it is an unnecessarily complex. Practices spend an average of 20 uncompensated hours per week on the paperwork and other components of obtaining prior authorization. Importantly, the vast majority of prior authorizations are eventually approved.

Prior authorization places a heavy administrative burden on physicians and pharmacists and wastes a lot of time and resources. Each insurer has its own arbitrary requirements and standards of approval for prior authorization requests. Not to mention, each insurer requires prior authorization for different drugs. Prior authorization often delays care, which can result in higher costs and poorer outcomes.

In an AMA survey on prior authorization, 91% of physicians reported delays in care due to prior authorization. 65% reported waiting at least one day and 26% reported waiting at least 3 business days for prior authorization decisions. 28% reported that PA led to a serious adverse event (e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event) and 91% felt that PA has a negative impact on clinical outcomes. Finally, 75% report that PA can lead to treatment abandonment1.

MAG principles on prior authorization are that: 1) Health plans, rather than physicians, should be responsible for checking its own database of information to verify the patient’s eligibility and coverage information during prior authorization; 2) Patient and health plan information website in conjunction with

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A request for prior authorization should be considered forever valid by the health plan for claims payment and any other audit process; 3) Health plans should only allow physicians who perform the medical service or procedure to submit the request for prior authorization; 4) Once a prior authorization request for a service or procedures is approved by the health plan, and the health plan validates the patient’s eligibility and coverage, the health plan is obligated to pay for the service that’s billed by the physician; 5) All managed care contracts should include the provisions that are highlighted in these principles; 6) All health plan requests for patient clinical information made in conjunction with a physician’s request for prior authorization should be commensurate with the complexity of the procedure or service that’s requested; 7) Health plans should provide a specific reason when they deny a medical service or procedure in response to a physician’s prior authorization request; 8) Prior authorizations should not be denied for a minor or immaterial mistake on the request form (i.e., change of date of service); 9) If a medical service is urgent, a health plan should not deny payment of that service for failure of a physician to obtain a prior authorization; 10) All health plans should clearly display a complete list, by name, description and CPT code of services or procedures, which require prior authorization, that’s easily obtainable by the attending physicians on its website and/or other normal methods of communication; 11) All health plans should provide a standard of acceptable prior authorization communication including contact by telephone, fax, and website; 12) Health plans should be transparent in their communication with physicians about the basis for their prior authorization program, including: (a) the specific criteria used for determining the medical necessity of the service and the accompanying administrative structure who oversees the process, i.e., national advisory boards, (b) the basis for placing a service/procedure on the prior authorization list; (c) the cost-effectiveness of the process and (d) the profits gained through denial of a PA service or procedure; 13) Health plans should eliminate the financial penalties that are levied against physicians for failing to obtain a prior authorization; 14) All health plans should have a central point for submission for all prior authorization requests, with additional options available as needed; 15) Health plans should standardize their response times to prior authorizations to between 24 to 48 hour that is obtained by a physician from the health plan’s; 16) Health plans should provide peer review services 24/7; 17) Peer review should consist of review by like specialty and practice setting; 18) Health plans should allow submissions of prior authorization requests without deadlines, other than that it occur before the service or procedure; 19) The list of services required for prior authorization by health plans should be reasonable, consistent among plans, and based on scientific literature which substantiates a reasonable need for the service to be questioned; it should not be solely based on the cost of the service.

2. Assignment of Benefits
Georgia passed a law in 2010, codified as OCGA 33-24-54, which requires that insurers to pay the benefits under the contract “directly to any similarly licensed nonparticipating or nonpreferred provider who has rendered such services, has a written assignment of benefits, and has caused written notice of such assignment to be given to the person licensed under this title or jointly to such nonparticipating or nonpreferred provider and to the insured, subscriber, or other covered person; provided, however, that in either case the person licensed under this title shall be required to send such benefit payments directly to the provider who has the written assignment.”

Despite this law, we frequently receive complaints from physicians that assignments of benefits are not honored by insurance companies. The insurers either tell the physician that the form used is not valid or the insurer issues payment to patients with no or inadequate explanation. The patient receives a check from his/her insurer and does not understand the money is supposed to be used to pay the physician, especially when that check comes months after the care was provided.

MAG would like to see the law enforced and would encourage the Commissioner’s office to explore remedies it has with its rule making powers to help enforce the law.
3. Network Adequacy
According to a 2015 study, 83 percent of networks in Georgia were considered small and 17 percent were considered medium\(^2\). These narrow networks impact patient choice by restricting the physicians that the patient can see within their network. This can also lead to surprise bills when a hospital is in the narrow network but one of the physician groups that provide services at that hospital is not.

Network adequacy is also especially important in light of the physician shortages that currently occur in these areas. One issue that contributes to shortages is low Medicaid reimbursement rates combined with too small of a population with private insurance or private insurance reimbursement rates that are too low to balance the low Medicaid rates.

MAG would like to see network adequacy standards put in place in Georgia to protect patients and to increase patient choice. Network adequacy laws can contain provider to enrollee ratios, network provider capacity, time and distance standards, and other standards.

4. Deselection and Take-It-or-Leave-It Contracts
Providers often find themselves being removed from insurance networks with little notice and/or explanation as to why they are being removed. This leads to patients experiencing interruption of care which can negatively impact the patient’s health. This often happens during the middle of a patient’s contract year when the patient may have selected their insurer/insurance plan based on their physician being advertised as in-network. This leads to a bait and switch that leaves the patient with insurance that will not cover their physician of choice.

At times, physicians will not be deselected, but rather, the physician will be offered “take-it-or-leave-it” rates that are so low that the physician cannot financially accept the rates and then become (or remain) out-of-network. With the federal discussion over surprise billing and the suggestion that the issue could be solved by utilizing the “median in-network rate,” we have seen an increase in the number of physicians in those specialties most commonly implicated in discussions about surprise billing receiving notices of reductions in rates that they must either accept or be removed from the network. These low rates allow insurers to drive down the median in-network rate and the physicians that cannot or will not accept the reduction find themselves out-of-network. These reductions harm the patient and continue to exacerbate already narrow networks.

Thank you for providing MAG with the opportunity to submit this letter detailing these issues. We look forward to working with you to improve the care for patients across Georgia. Please do not hesitate to reach out to Derek Norton at dnorton@mag.org or (404) 274-4210 if you have any questions.

Sincerely,

Rutledge Forney, M.D.
MAG President

CC: Donald Palmisano, MAG Executive Director/CEO